

Form AID-CS-Complaint (9/06)



## **Arkansas Insurance Department**

## **CONSUMER COMPLAINT FORM**

1 Name Address Sta Sta Telephone No	Little Rock, AR 72201-1904 Phone: 501-371-2640 or 800-852-5494 Fax: 501-371-2749
2 Company	☐ Automobile ☐ Homeowners ☐ Life ☐ Health ☐ Other How were you referred?
4 Explain below the problem you are experience inquiry.	ing. Also, please attach copies of any information you have regarding this
Release of Information: My signature on this form community information or documentation from any legal entity of this form will be considered valid authorization.	onstitutes my authorization for the Arkansas Insurance Department to obtain it deems necessary for the resolution of my complaint/inquiry. A photocopy
SIGNATURE	DATE

## The following information must be included with your complaint:

- · Name, address and telephone number of person filing the complaint
- Name of the insurance company
- Name of person insured
- Policy number and claim number (if applicable)
- Agent or adjuster's name
- Date of occurrence
- A brief description of why the complaint is being filed. Attach copies of documents that will help with the investigation.

Once we receive your correspondence, it will be assigned to an investigator who will review it and take the necessary steps to resolve this matter.

Our job is to serve the citizens of Arkansas and assist them with their insurance questions or problems. We appreciate your interest.

## AUTHORIZATION FOR RELEASE OF HEALTH INFORMATION TO THE ARKANSAS INSURANCE DEPARTMENT

I,	authorize
(name of consumer)	(name of insurer or other party)
to disclose the following health information to the e request:	mployees of the Arkansas Insurance Department upon
(specific and meaningful descri	ption of the information to be provided)
This authorization is valid for 24 months from the d authorization, I can do so by sending a written reque	ate of signature, unless revoked. If I wish to revoke this est to the Arkansas Insurance Department.
I understand that I have the right to revoke this authorized	orization in writing, unless
has already taken action under the authorization.	(name of covered entity)
	ance Department may be subject to disclosure by the The Arkansas Insurance Department will not disclose your
Signature of consumer (or personal representative o authority)	f consumer, along with description of the representative's
 Date	